CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

Revised November 6, 2002

H.R. 5250
Veterans Health Care Funding Guarantee Act of 2002

As introduced on July 26, 2002

SUMMARY

H.R. 5250 would require the Secretary of the Treasury to make available to the Veterans Health Administration (VHA) each fiscal year, beginning in 2004, an amount determined under the bill, to be available without fiscal year limitation for VHA's programs, functions, and activities. Under H.R. 5250, the amount in 2004 would be equal to 120 percent of the total obligations made by the VHA in 2002. The amounts in succeeding years would be adjusted for medical inflation and growth in the number of veterans enrolled in VHA's health care system and other nonveterans eligible for care from VHA.

Although the bill would primarily affect funding for health care services provided by VHA—replacing annually appropriated discretionary funding with direct spending, it also would result in some savings in direct spending for other government programs including Medicare and Medicaid.

CBO estimates that enacting H.R. 5250 would result in a net increase in direct spending totaling about $25 billion in 2004, $148 billion over the 2004-2007 period, and $431 billion over the 2004-2012 period. Under the bill, funding for VHA would be considered direct spending, so CBO estimates that discretionary outlays for VHA and other government programs would decline—relative to current baseline projections—by $8 million in 2003, about $21 billion in 2004, and $237 billion over the 2003-2012 period. That potential discretionary savings assumes that appropriations are reduced from baseline levels by the estimated amounts.

H.R. 5250 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). Lower Medicaid spending for veterans who would now receive health services through the Veterans Health Administration would result in savings to states of about $350 million over the 2005-2007 period, and $1.3 billion over the 2005-2012 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 5250 is shown in Table 1. The costs of this legislation fall within budget functions 050 (national defense), 550 (health), 570 (Medicare), and 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY IMPACT OF H.R. 5250

	By Fiscal Year, in Millions of Dollars				
	2003	2004	2005	2006	2007
CHANGES IN DIRECT SPENDING					
Estimated Budget Authority	0	27,942	37,461	42,489	47,619
Estimated Outlays	0	25,148	30,056	42,019	50,456
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	0	-23,724	-24,512	-25,280	-26,096
Estimated Outlays	-8	-20,592	-23,702	-24,924	-25,849

BASIS OF ESTIMATE

This estimate assumes that the bill is enacted before the end of calendar year 2002 and that future appropriations are reduced by the estimated amounts.

Direct Spending

Under H.R. 5250, direct spending for VHA would increase significantly but would be offset in part by some savings in direct spending for other government programs, including Medicare and Medicaid. On balance, CBO estimates that enacting H.R. 5250 would result in a net increase in direct spending totaling $148 billion over the 2004-2007 period (see Table 2) and $431 billion over the 2004-2012 period.

Veterans Health Administration. Under current law, funding for VHA is provided in an annual appropriation. That appropriation typically includes funds for medical care for veterans (the bulk of the appropriation); funds for construction or renovation of hospitals, nursing homes, and clinics; and funds to pay operating expenses. Under H.R. 5250 beginning in fiscal year 2004, the funding for all of VHA's programs, functions, and

activities would be provided through a permanent, indefinite appropriation directly by the Treasury, except for a program that provides grants to states to build long-term care facilities. CBO estimates that, under H.R. 5250, direct spending for veterans health care would increase by about $25 billion in 2004, $152 billion over the 2004-2007 period, and $448 billion over the 2004-2012 period.

TABLE 2. ESTIMATED CHANGES IN DIRECT SPENDING UNDER H.R. 5250

	By Fiscal Year, in Millions of Dollars				
	2003	2004	2005	2006	2007
CHANGES IN DIRECT SPENDING					
Veterans Health Administration					
Estimated Budget Authority	0	27,942	38,562	43,949	49,443
Estimated Outlays	0	25,148	31,157	43,479	52,280
Medicare					
Estimated Budget Authority	0	0	-1,032	-1,368	-1,708
Estimated Outlays	0	0	-1,032	-1,368	-1,708
Medicaid					
Estimated Budget Authority	0	0	-137	-153	-172
Estimated Outlays	0	0	-137	-153	-172
Veterans Benefits Administration					
Estimated Budget Authority	0	0	80	78	77
Estimated Outlays	0	0	80	78	77
Federal Employees Health Benefits Program					
Estimated Budget Authority	0	0	-12	-17	-21
Estimated Outlays	0	0	-12	-17	-21
Total Changes					
Estimated Budget Authority	0	27,942	37,461	42,489	47,619
Estimated Outlays	0	25,148	30,056	42,019	50,456

Under H.R. 5250, the Treasury would be required to make available in 2004 to VHA an amount that is specified in the bill as 120 percent of the total obligations made by VHA in fiscal year 2002. According to VHA, obligations in 2002 are expected to total a little more than $23 billion. Thus, CBO estimates that under H.R. 5250 the Treasury would make about $28 billion available to VHA in 2004, resulting in direct spending outlays of about $25 billion. (The corresponding reduction in discretionary spending under the bill is discussed below under the heading of "Spending Subject to Appropriation.")

For each year after 2004, H.R. 5250 would establish a baseline per capita cost equal to the amount that would be provided by the Treasury in fiscal year 2004 divided by the number of veterans enrolled to receive medical care from VHA at the end of fiscal year 2002. CBO estimates that this per capita cost would be about $4,550 in 2004. This baseline amount would then be increased each year at the rate for medical inflation published by the Bureau of Labor Statistics (BLS). For each year after 2004, the Treasury would be required to make available to VHA an amount equal to the inflated per capita amount for that fiscal year times the number of veterans enrolled to receive medical care from VHA as of July 1 of the previous fiscal year. Under current law, most veterans have to enroll with VHA before they can receive care from VHA. Many enrolled veterans, though, do not actually receive any care from VHA.

Some nonveterans are eligible to receive care from VHA without being enrolled with VHA. Under the bill, the number of those nonenrolled individuals who received care from the VHA in the previous fiscal year would also be counted with the number of enrolled veterans for the purposes of determining funding for VHA. Nonenrolled individuals who are eligible to receive health care from VHA include dependents of veterans who are either 100 percent disabled or who have a total and complete disability.

Estimate of the Number of Enrolled and Nonenrolled Individuals. According to VHA, about 6 million veterans are enrolled in VHA's health care system for 2002 and that number is projected to grow under current law to more than 8 million veterans by 2012. Even without that projected increase in enrollment, VHA is having difficulty providing health care to all currently enrolled veterans. Instead of attempting to treat all enrolled veterans, VHA now gives veterans with service-connected disabilities higher priority when providing health care because its appropriation is not sufficient to meet the health care demands of all currently enrolled veterans. Thus, CBO believes many veterans who have not yet enrolled would do so if more funding and, thus, more health care were provided. Under H.R. 5250, CBO estimates that by 2012 total enrollment would increase by 25 percent above current VHA projections because VHA would have a guaranteed source of funding for newly enrolled veterans. Accordingly, CBO estimates that under H.R. 5250, slightly more than 10 million veterans or about half of all living veterans would be enrolled to receive health care from VHA in 2012. (That amount is about 2 million more veterans than VHA currently projects for 2012 under current law.)

While this may seem a large percentage increase, VHA currently projects that the number of veterans enrolled to receive health care will comprise about 40 percent of all living veterans by 2012. Said another way, CBO estimates that only one out of six veterans not yet enrolled would enroll under H.R. 5250 by 2012. While this is CBO's best estimate, there is some risk that enrollment could be higher than our estimate of 10 million veterans by 2012 which would lead to higher costs than we currently estimate.

Under H.R. 5250, CBO believes enrollment would be higher than the current-law projections because veterans would have a greater incentive to enroll and VHA would be increasingly motivated to enroll them. That greater incentive stems from the fact that there would be a guaranteed funding source for medical benefits under the bill. VHA provides generous health care benefits that many veterans already receive today. Data and projections from VHA indicate that enrollment has been and continues to increase even though VHA is unable to provide all of the health care that veterans are seeking. With a significant increase in funding to provide those benefits, CBO expects even more veterans would enroll in order to use the benefits provided by VHA. Using the increased and guaranteed funding that would be made available under H.R. 5250, VHA would be able to provide health care to more veterans and provide that health care in a more timely manner; thus increasing the likelihood of more veterans enrolling.

In addition, under H.R. 5250, VHA's budget authority would be directly linked to the number of veterans it is able to enroll, not the number of veterans who actually receive care at VHA. As mentioned above, many enrolled veterans do not actually receive any health care from VHA. Thus, the more veterans VHA enrolls the more effectively it would be able to fulfill its mission to provide health care to all veterans that seek that care from VHA. Accordingly, CBO estimates that the total number of enrolled veterans would increase significantly above current projections.

In addition to providing care to enrolled veterans, VHA also provides health care to many individuals who are not veterans. Dependents and survivors of certain veterans, primarily those who are either 100 percent disabled or have a total and complete disability, can participate in a program called CHAMPVA that acts as a third-party insurance provider for those individuals. Using information from VHA, CBO estimates that in 2004 there would be about 175,000 individuals in the CHAMPVA program who would be counted in the formula to determine VHA's annual budget authority under H.R. 5250.

Estimate of VHA Spending. Using the formulas specified in H.R. 5250 and the above estimates of population and per capita costs, CBO estimates that under H.R. 5250 direct spending by VHA would increase by about $25 billion in 2004, $152 billion over the 2004-2007 period, and $448 billion over the 2004-2012 period.

Under the bill, the amount VHA would receive in 2005 would be significantly more than what it would receive in 2004. That difference would occur because the budget authority for the two years would be calculated differently. For 2004, budget authority would be equal to 120 percent of obligations in 2002. For 2005, budget authority would be equal to the inflated per capita amount multiplied by the number of veterans enrolled to receive health care from VHA as of July 1, 2004, plus the number of individuals in the CHAMPVA program who received care from VHA in fiscal year 2004. The baseline per capita amount is derived by dividing the 2004 budget authority ($28 billion) by the number of enrolled

veterans in 2002 (6 million) which is then inflated at the medical inflation rate published by the BLS. CBO estimates that the number of veterans and other individuals in 2004 would be almost 2 million people more than in 2002—generating the large increase in budget authority for 2005. Only about 900,000 of the 2 million person increase would result from CBO's projected increase in enrollment under H.R. 5250. The remaining increase includes 175,000 CHAMPVA beneficiaries who are not counted when determining the per capita amounts and the increased enrollment that VHA projects under current law would occur even in the absence of H.R. 5250. That increase in the population accounts for most of the increase in budget authority.

Under the bill, the first significant increase in budget authority would occur in 2005. Because it would take some time before VHA could adjust its spending of the larger budget authority, CBO estimates that increases in outlays would lag the increases in budget authority for two years. By 2007, CBO expects that VHA would be able to obligate and spend the increased amounts in a normal manner (close to historical rates of spending). Estimated outlays would exceed budget authority in 2007 because a significant amount of lagged outlays from prior years' budget authority would be combined with normal, first-year spending of the new 2007 budget authority. CBO expects that the adjustment back to historical outlay rates would take only two years because VHA has extensive authority to contract with non-VHA health care facilities—especially to provide long-term care needs such as nursing home care, home health care, adult day care, and respite care to veterans that they cannot provide for in their own facilities. Additionally, VHA would have almost two years to prepare plans to make use of that first significant increase.

Medicare. About half of all enrolled veterans are also eligible for Medicare benefits. While benefits provided by VHA include many benefits provided by Medicare, VHA also provides a prescription drug benefit and a long-term care benefit that is not currently provided by Medicare. As mentioned above, under H.R. 5250, VHA would be able to provide health care to more veterans and increase its spending per veteran. Thus, CBO expects that veterans treated by VHA would use Medicare somewhat less than they currently do. While the increased spending on health care would not result in dollar-for-dollar savings in Medicare, CBO estimates that Medicare spending on veterans who use VHA for health care would decline.

Using population and budget data from VHA, CBO estimates that under current law per capita spending by VHA on veterans receiving care would be about $4,950 in 2005. Under H.R. 5250, CBO estimates that spending would increase by almost $2,300 for veterans who currently use VHA to receive health care services. Thus, for veterans who would begin to use VHA for the first time under H.R. 5250, per capita spending would be about $7,200. Because VHA provides substantial health care benefits that Medicare does not currently provide, CBO believes that veterans would disproportionately demand those services (prescription drugs and long-term care) when seeking care from the Veterans Health

Administration. In other words, less than half of all new spending on veterans' health care would replace Medicare-covered services.

CBO estimates that for veterans age 65 and older Medicare pays for about 50 percent of their total health care expenditures, and that under H.R. 5250 VHA would pay for about half of the expenditures now paid for by Medicare. Thus, for those veterans who currently receive health care from VHA, CBO assumes that Medicare spending would be reduced by about 25 percent of the estimated increase in average spending by VHA. For those veterans who would begin to receive health care from VHA for the first time, CBO assumes that Medicare spending would decrease by about 25 percent of the total per capita amount that VHA would spend on Medicare-eligible veterans under H.R. 5250. Thus, the reduction in spending by Medicare would only partially offset the increased spending by VHA.

Because the large increase in VHA's budget would not occur until 2005, CBO estimates that these savings also would not occur until 2005. CBO estimates that under H.R. 5250 Medicare spending would decline by about $1 billion in 2005, $4 billion over the 2005-2007 period, and $16 billion over the 2005-2012 period.

Medicaid. Using data from the Current Population Survey (CPS) and VHA, CBO estimates that under H.R. 5250 more than 8,500 veterans who would have used Medicaid would now use VHA for health care in 2005, with that number growing to almost 31,000 by 2012. CBO believes that most of the veterans that would initially use VHA for health care would be those veterans who are eligible for a pension from the Veterans Benefits Administration (VBA) and are in Medicaid-approved nursing homes. Under current law, veterans who are in Medicaid-approved nursing homes and are also eligible for a pension from VBA must forfeit the majority of their pension; these veterans may keep only about $90 a month. If, however, veterans are in a VHA-sponsored nursing home, the veterans forfeit a much smaller percentage of their pension. Because VHA would have more money to spend on nursing home care under H.R. 5250, CBO expects that many veterans would choose to use VHA for nursing home care instead of Medicaid.

CBO estimates that in 2005, about 14,000 veterans who are eligible for a pension would be in nursing homes paid for by Medicaid with that number declining to about 10,000 by 2012. Based on programmatic experience, CBO assumes that about half of those veterans would switch to receive their nursing home care from VHA with an average savings to Medicaid of about $18,500 in 2005. CBO estimates that the number of Medicaid-eligible veterans who are not in nursing homes that would begin to use VHA for some health care would total about 1,500 in 2005, and grow to about 25,000 veterans by 2012. The savings associated with those veterans, CBO estimates, would be much less—at about $4,000 per veteran in 2005—because the ability of veterans to participate in both programs would be unchanged under H.R. 5250. Accordingly, CBO estimates that savings in the Medicaid program would

be $137 million in 2005, $462 million over the 2005-2007 period, and $1.7 billion over the 2005-2012 period.

Veterans Benefits Administration. As mentioned above, veterans who are eligible for a pension from VBA and are in Medicaid-approved nursing homes must forfeit the majority of that pension. Thus, under H.R. 5250, CBO estimates that VBA would have to pay significantly more each year in pension payments for each veteran that is eligible for a pension and who would now receive nursing home care from VHA instead of Medicaid. CBO estimates that the additional pension payments would be about $11,000 per veteran in 2005. Using the above assumption that 50 percent of those veterans in Medicaid-approved nursing homes (7,000 in 2005) would choose to receive nursing home care from VHA, CBO estimates that the costs to VBA would be $80 million in 2005, $235 million over the 2005-2007 period, and $530 million over the 2005-2012 period.

Federal Employees Health Benefit (FEHB) Program. Using data from the CPS and VHA, CBO estimates that in 2005 about 80,000 civilian retirees of the federal government also would receive health care from VHA with that number growing to about 100,000 retirees in 2012. Health care spending for retirees from the federal government is considered direct spending. Most civil service retirees age 65 and over also are eligible for Medicare and thus would have little incentive to use VHA services except for benefits not covered by Medicare and FEHB, primarily long-term care. Thus, CBO estimates that the per capita savings to the FEHB program would be somewhat smaller than the savings for those veterans enrolled in Medicare. CBO estimates that under H.R. 5250 health care expenditures for veterans who retired from the federal government would decline by $12 million in 2005, $50 million over the 2005-2007 period, and $194 million over the 2005-2012 period.

Tricare-for-Life. The Department of Defense (DoD) operates a program called Tricare-for-Life that pays all copayments and deductibles for Medicare-covered services and provides a generous prescription drug benefit for all retirees of the uniformed services who are eligible for Medicare. Those retirees also would be eligible to receive health care from VHA, but given the extent of their current insurance, CBO does not expect many retirees to use VHA for health care except for long-term care needs, which are not covered by Medicare or Tricare-for-Life. Thus, CBO does not estimate any significant savings in the Tricare-for-Life program from enacting H.R. 5250.

Spending Subject to Appropriation

H.R. 5250 also would affect discretionary spending by reducing VHA's need for future appropriations and increasing the amount of offsetting collections deposited to the Medical Care Collections Fund (MCCF). As shown in Table 3, CBO estimates that implementing

H.R. 5250 would lower discretionary outlays by $8 million in 2003, $95 billion over the 2003-2007 period, and $237 billion over the 2003-2012 period, assuming appropriations are reduced by the estimated amounts.

TABLE 3. ESTIMATED CHANGES IN SPENDING SUBJECT TO APPROPRIATION FOR H.R. 5250

	By Fiscal Year, in Millions of Dollars					
	2002	2003	2004	2005	2006	2007
VETERANS HEALTH ADMINISTRATION						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	22,266	23,094	23,828	24,573	25,330	26,133
Estimated Outlays	22,207	23,019	23,596	24,266	25,020	25,813
Veterans Medical Care						
Estimated Authorization Level	0	0	-23,724	-24,467	-25,222	-26,023
Estimated Outlays	0	0	-20,581	-23,650	-24,853	-23,760
Offsetting Collections						
Estimated Authorization Level	0	0	0	0	0	0
Estimated Outlays	0	-8	-11	-14	-16	-19
Subtotal						
Estimated Authorization Level	0	0	-23,724	-24,467	-25,222	-26,023
Estimated Outlays	0	-8	-20,592	-23,664	-24,869	-25,779
Spending Under H.R. 5250						
Estimated Authorization Level	22,266	23,094	104	106	108	110
Estimated Outlays	22,207	23,011	3,004	602	151	34
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	10,273	11,222	12,090	12,905	13,743	14,637
Estimated Outlays	10,273	11,222	12,090	12,905	13,743	14,637
Proposed Changes						
Estimated Authorization Level	0	0	0	-11	-14	-18
Estimated Outlays	0	0	0	-11	-14	-18
Spending Under H.R. 5250						
Estimated Authorization Level	10,273	11,222	12,090	12,894	13,729	14,619
Estimated Outlays	10,273	11,222	12,090	12,894	13,729	14,619

(Continued)

TABLE 3. CONTINUED

	By Fiscal Year, in Millions of Dollars					
	2002	2003	2004	2005	2006	2007
DEFENSE HEALTH PROGRAMS						
Baseline Spending Under Current Law						
Estimated Authorization Level [a]	18,259	18,590	18,979	19,406	19,853	20,320
Estimated Outlays	15,064	18,526	18,783	19,188	19,643	20,098
Proposed Changes						
Estimated Authorization Level	0	0	0	-34	-44	-55
Estimated Outlays	0	0	0	-27	-41	-52
Spending Under H.R. 5250						
Estimated Authorization Level	18,259	18,590	18,979	19,372	19,809	20,265
Estimated Outlays	15,064	18,526	18,783	19,161	19,602	20,046
SUMMARY OF CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	0	-23,724	-24,512	-25,280	-26,096
Estimated Outlays	0	-8	-20,592	-23,702	-24,924	-25,849

a. The 2002 level is the estimated net amount appropriated for that year. No full-year appropriation has yet been provided for fiscal year 2003. The current-law amounts for the 2003-2007 period assumes that appropriations remain at the 2002 level with adjustments for anticipated inflation.

Reduced Appropriations for VHA. Under H.R. 5250, VHA would no longer need most of its annual appropriation. The only remaining appropriated spending for VHA would be for the spending of offsetting collections and grants that are made to states to construct long-term care facilities, for which the Congress appropriated $100 million for fiscal year 2002. CBO estimates that funding VHA directly from the Treasury would save about $21 billion in 2004, $95 billion over the 2004-2007 period, and $237 billion over the 2004-2012 period, assuming appropriations are reduced by the estimated amounts. Those are the amounts currently projected in the CBO baseline for discretionary spending. The baseline is derived by inflating the most recent full-year appropriation for a program. Future appropriation levels may be either higher or lower than such baseline projections.

Offsetting Collections. Under current law, certain veterans must make copayments when receiving health care from VHA. In addition, VHA can bill a veteran's third-party insurance when the veteran is treated for nonservice-connected conditions. These payments are deposited into the MCCF and, under current law, are treated as offsets to discretionary spending. Spending from the MCCF is subject to appropriation.

As mentioned earlier, CBO estimates that under H.R. 5250 total enrollment in VHA's health care system would increase by 25 percent. Although direct funding from the Treasury would not begin under the bill until 2004, CBO expects that enrollment would begin to increase in 2003 in anticipation of guaranteed funding in 2004. CBO estimates that the increase in the number of veterans who actually receive care from VHA would increase more slowly with about 100,000 new users in 2003, growing to more than 1.3 million by 2012.

Based on that estimated increase, CBO estimates that collections would increase by $19 million in 2003, $355 million over the 2003-2007 period, and about $1.2 billion over the 2003-2012 period. When the amounts in the MCCF are appropriated, the budget authority for collections and spending of the collections offset each other exactly in each year, but there is a lag in outlays. CBO estimates that the lag in outlays would decrease spending by $8 million in 2003, by $68 million over the 2003-2007 period, and $142 million over the 2003-2012 period, assuming the appropriation of the amounts in the MCCF.

Federal Employees Health Benefits Program. As mentioned above, veterans who work for the federal government are eligible to receive health care from VHA and most are likely enrolled in the FEHB program. Spending on FEHB for current employees is subject to appropriation. Using data from the CPS and VHA, CBO estimates that about 120,000 federal workers with FEHB also would use VHA for some health care services in 2005 with that number growing to about 150,000 by 2012. CBO estimates that the savings would be much lower on a per capita basis than for the FEHB annuitants, because medical costs are highly correlated with age. CBO estimates that implementing H.R. 5250 would reduce expenditures for FEHB by $11 million in 2005, $43 million over the 2005-2007 period, and $160 million over the 2005-2012 period, assuming appropriations are reduced by the estimated amounts.

DoD Retiree Health Care. All military retirees are, by definition, veterans. DoD provides third-party health care insurance as well as direct care in military hospitals and clinics to retirees. Spending on health care for military retirees who are under age 65 and not eligible for Medicare is subject to appropriation. While exact numbers are not available, CBO estimates that a little more than 90,000 retirees would receive some health care from VHA in 2005, and that number would grow to about 110,000 in 2012. Assuming slightly lower per capita savings as with federal retirees, CBO estimates that implementing H.R. 5250 would save $27 million in 2005, $120 million over the 2005-2007 period, and $475 million over the 2005-2012 period, assuming appropriations are reduced by the estimated amounts.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 5250 contains no intergovernmental or private-sector mandates as defined in UMRA. Lower Medicaid spending for veterans that would now receive health services through the

Veterans Health Administration would result in savings to states of about $350 million over the 2005-2007 period, and $1.3 billion over the 2005-2012 period.

PREVIOUS CBO ESTIMATE

On August 27, 2002, CBO transmitted an estimate of this same bill, H.R. 5250, the Veterans Health Care Funding Guarantee Act of 2002, as introduced on July 26, 2002. While this revised estimate is similar to the earlier estimate, there are some important differences. The revised estimate of H.R. 5250 includes an estimate of savings to other federal health care programs—primarily Medicare and Medicaid—that would occur if H.R. 5250 were enacted. This is the most significant difference between the two estimates. Because H.R. 5250 would dramatically increase the amount of funding available to provide health care to veterans, some of those veterans would be able to get care from VHA and would use current federal health care programs less intensively. Including those effects, lowers our estimate of total direct spending by about $17 billion over the 2004-2012 period. In addition, our estimate of savings in programs subject to appropriation increased by about $1 billion over the 2004-2012 period, although those savings would only occur if appropriations were reduced by the estimated amounts.

The revised estimate also takes into account the CHAMPVA beneficiaries who are eligible to receive care from VHA when determining the amount that would be available to VHA. The estimate transmitted on August 27, 2002, did not include those individuals. Adding those individuals into the formula increased our estimate of outlays of direct spending for VHA by $10 billion over the 2004-2012 period.

This revised estimate also corrects a calculation error where we mistakenly multiplied the per capita amount in each year by the number of veterans in that year instead of the previous year. Fixing that error lowered our estimate of outlays for direct spending by VHA by about $13 billion over the 2004-2012 period. Thus, the net change in estimated outlays for VHA is now about $3 billion less over the 2004-2012 period.

In the previous CBO estimate, we estimated the first-year outlay rate for VHA would be 91 percent, even with a significant increase in budget authority. For this revised estimate, we incorporate a two-year adjustment period, with lower first-year outlay rates for 2005 and 2006. Lowering the first-year outlay rates produces some savings over the 2004-2007 period, but has almost no effect over the 2004-2012 period, because outlays would be shifted into later years. Changing the outlay rates reduced the estimate of outlays of direct spending for VHA by $3 billion over the 2004-2007 period, but by only $1 billion over the 2004-2012 period.

The revised estimate also adjusts our estimate of offsetting collections that VHA would collect as more veterans received health care from VHA. The earlier estimate used enrollment as a proxy for increased collections. In the revised estimate, the estimate of offsetting collections is based on our estimate of the number of newly enrolled veterans that would actually use VHA for health care services. The revised estimate of offsetting collections is smaller by about $700 million over the 2003-2012 period. As mentioned above, the budget authority for the collections and the spending of those collections offset each other exactly in each year, but the outlays tend to lag collections—generating some near-term savings. Because estimated collections are lower in the revised estimate, the lag in outlays would generate lower savings than we previously estimated. Thus, the net impact on outlays from the revised estimate of collections is that savings are reduced by about $40 million over the same period, assuming appropriation of the offsetting collections.

In total, this revised estimate of direct spending over the 2004-2012 period is about $21 billion less than our original estimate. For spending subject to appropriation, our estimate of potential savings, if appropriations are reduced by the estimated amounts, is about $1 billion higher than our original estimate.

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